Total Encounters

The Life and Times of the Mental Health Centre Penetanguishene

Robert F. Nielsen

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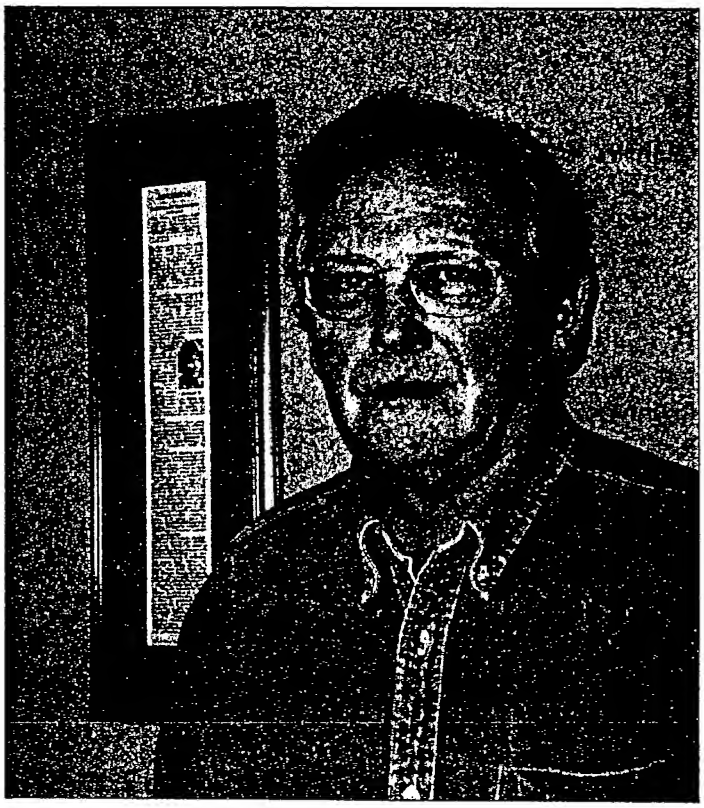

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Naked in the Box

Dr. Boyd, when Dr. Barker came to you and said, "We want to create a Total Encounter Capsule and the patients will go in naked if they agree"—did you ever look at each other and say, "Will the government go for this?" or "My God! What will the press say?"
Dan Parle, MHCP Public Information Officer, 1990

The term therapeutic community (TC) was first commonly used by British psychiatrist Maxwell Jones, who developed the concept while working with shell-shock victims during World War II. In 1947 he established perhaps the most famous therapeutic community in the world at Belmont Hospital in London. At the heart of the approach is the notion of a community as a unified body of individuals involving "shared responsibility and decision making, open communication, and learning as a social process" (Toch 37).

TCs have been incorporated into many different settings, although it was often difficult because the egalitarian foundation of the concept challenges the status quo based on money, authority, and status. Nowhere does the task seem more daunting than in a high-security institution, usually run on highly authoritarian lines. Yet this was the task that Dr. Elliott Barker set himself when he became director of the Social Therapy Unit at Oak Ridge. Jones's work struck a chord with Barker, who had strong egalitarian beliefs. ("I always thought Jones was God," he once commented (Personal.)) A patient recorded his impressions of Barker's arrival at Oak Ridge:

> He spent his first two months simply wandering around, sizing up the place. It was immoral to have a psychiatrist wandering around. Previously, the psychiatrists had learned to race to their offices as quickly as possible to avoid the

> clinging conversations of three hundred patients who wanted to know when they were going to be released. When they did talk to patients, they were evasive, stiff and anxious to get to their offices before someone else came along. Elliott would just stop by in the Industrial Therapy shops or on the ward, and actually pass the time of day with you. He would ask you questions about what you were doing. It was immensely gratifying for you to be the focus of attention, rather than him (Barker and Gifford).

Taking up where Boyd had left off, Barker designed a TC with a specific purpose. The antithesis of the usual maximum security institution with its inmates sitting, smoking and rotting, the Social Therapy Unit at Oak Ridge should be set up so that a patient's whole day would be spent getting better. Not enough staff? Then the patients must do it themselves!

Dr. Elliott Barker

During 1965 Boyd had stepped up recruiting, and in July four psychiatrists were added to the roster: Drs. Snow, Lucas, Derby, and Barker. Boyd considered Elliott Barker the ideal person to orchestrate the further evolution of Oak Ridge, and wrote to him while he was on a trip around the world following his marriage. Barker wrote back saying that they'd need a place to live, and a job for his wife Julie, a graduate of the Ontario College of Art.

Undaunted, Boyd wrote back to inform them that a teaching position had been found for Julie, as well as a four-bedroom house 100 yards from the Red Dock swimming area. Recalling that he and Barker had been Boy Scout leaders together, Boyd pointed out that the scouts in Penetanguishene were more resourceful than in Hamilton. As to the job, Oak Ridge was preparing for "the year of the big leap forward: Our biggest need is a program of Group Dynamics for the Oak Ridge patients, and a program of Staff Education, and I expect Elliott will be interested in this." Boyd knew that the "absolute untouched gold mine" at Oak Ridge would mean more to Barker than Penetanguishene's comparatively low salaries.

Born in Buffalo, New York, Elliott Barker grew up in Toronto. After obtaining his MD from the University of Toronto, he was interning at St. Michael's Hospital in 1959 when he considered spending a year in psychiatry. On a whim he drove to the hospital in Hamilton and introduced himself. Superintendent John Senn gave him a warm welcome, as did his assistant, Boyd. Barker spent

Dr. Elliott Barker, 1970s

a year working with Boyd, and later earned his psychiatric certification.

Barker was later described by his successor, Gary Maier, as a man of charisma, "always exciting, a fountain of wisdom about life. There are some movie actors who are very shy, but when they're given permission by the director, they become very dramatic. Elliott was like that in his personality makeup....He had a calling to the ministry, and—although I don't think he'd say it this way—he became sort of a New Age minister, a psychiatrist (Personal).

Elliott and Julie Barker arrived in Penetanguishene fresh from their global tour. They had visited TCs in various countries, including China, where they had a rare tour of the Central Peking Prison. Barker continued the process of transforming Oak Ridge's program from one that was maintenance-oriented, using the traditional psychiatric measure of tranquilizers and ECT, to one that met his concept of a therapeutic community.

> My original vision was that I wasn't really dealing with patients. I thought we could evolve a social structure where people could resolve the internal conflicts in community, and it was the structure that would do that—if you could hit the right structure (Personal).

Barker set his sights on G Ward, where about half the patients were diagnosed as psychopaths and the other half as schizophrenics. Later, other wards would be incorporated into the program, although many patients would be deemed unsuitable, primarily because of lack of verbal skills. These men were assigned to the Activity Therapy Unit, which featured a more traditional program of behavioural objectives, focused on eliminating aggressive, antisocial behaviour and enhancing work and life skills.

Barker believed the key to overcoming mental illness was to facilitate communication. The Social Therapy Unit began in September 1965, with a group of young men of normal intelligence. They became quickly immersed in intensive compulsory therapy, sometimes as much as eighty hours a week, in a variety of structures.

Already in place were ward committees, each of which was now responsible for some aspect of treatment. Everybody on G Ward participated regularly in group therapy in the sunroom. The task was to effect mutual cures, with everybody helping everybody else. Therapy also continued for an hour each day in dyads (pairs) and triads.

One result of continuous therapy was escalating anxiety, as patients constantly badgered one another to reveal their innermost thoughts. Violent emotions erupted that hitherto had been repressed. However, anyone in distress was cared for by the group. A patient might even be attached by leather cuffs (a patient's invention) to another, to ensure his safety.

Group therapy in the sunroom escalated as confidence in the program grew. To break through to hard-to-reach psychopaths, a concept from California was introduced called the "marathon therapeutic process," based on the belief that if therapy went on long enough, no one could escape its effects. Hence, four groups of patients over the course of eight months spent weeks locked in psychic combat, sometimes called the Hundred Day Hate-In:

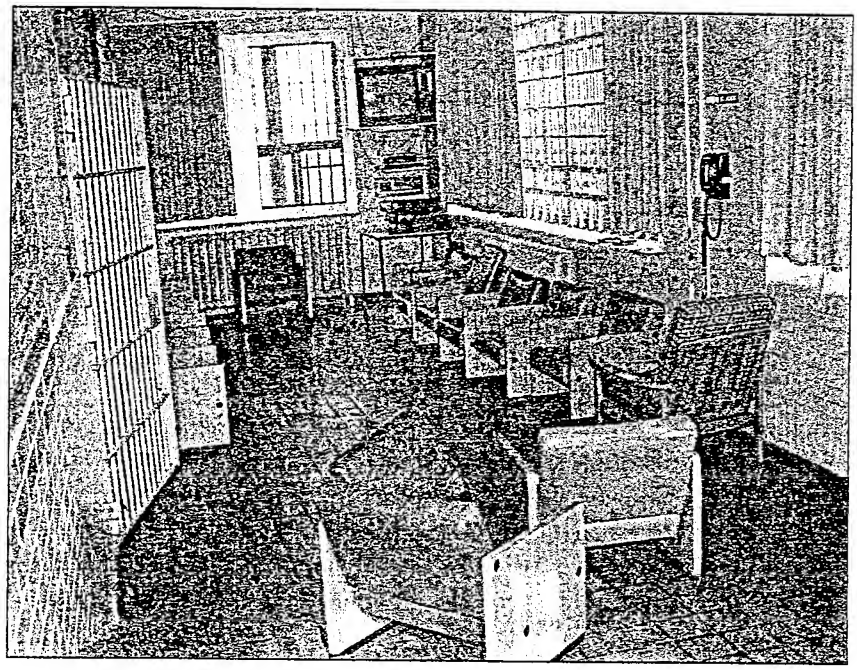
> There would be no clocks or calendars by which to keep schedules, and no diversionary contacts with the outside world.... The retreat into sleep itself would be rendered difficult by the continuing glare of the bright lights on the ceiling. In place of structure and routine would be the inescapable presence of the other with whom one shared eating, sleeping, and eliminating for an indefinite period that would end not when the inhabitants wanted, but when it was felt that the treatment had taken effect (Weisman 282).

Barker expected this intensive therapy to produce tension, perhaps feelings of despair, but at the same time to increase therapeutic movement. These hopes were not fully realized in the first session:

> Certainly there were desperate efforts to leave the situation—Barker and Mason mention the "tide of demands, pleas, threats, cajolements, and manipulations" (Barker & Mason).... What emerged from the group, however, was less hostility than silence and indifference.... Despite the pressures generated by this environment, each of the groups eventually reached a limit to mutual involvement .... Towards the end of the first group, patients began to find ways to use even the slender resources of the compressed

Above: C sunroom therapy place.

Right: A meeting.



Above: One of the sunrooms in which group therapy sessions took place.

Right: A ward council meeting.

> encounter unit for amusement and distraction. A thread could be unwound from a sock and placed through a button that in turn could be used to catch flies (Weisman, 282–283).

Even eating, sleeping, or looking out the window could provide respite from therapeutic interaction. The solution came in the form of the Total Encounter Capsule. Built on the second floor of Oak Ridge, it was a windowless, soundproofed room, eight feet wide and ten feet long. Its walls were painted green, it had a green wall-to-wall floor mat, and it was empty except for a sink and a toilet. Straws projecting through the door offered liquid sustenance: soup, juice, milk, coffee, and eggnog. The ceiling contained a one-way mirror, and television cameras were trained through holes in the walls—one of the earliest instances of videotape used as a tool for therapy.

The Capsule was designed "to function as a place of undisturbed security where a small group of patients could focus upon issues they felt important enough to warrant the exclusion of the usual physical and psychological distractions" (Barker and McLaughlin). Although the STU program as a whole was mandatory, all participants in the Capsule were volunteers, and each agreed to enter for a specified number of days. They entered without clothing, because of the belief that a naked person would be more inclined to reveal naked thoughts.

The Capsule was operated by patients, who kept watch at all times. They videotaped proceedings, kept records, supplied sustenance, maintained a comfortable temperature, and were prepared to intervene in an emergency.

To further enhance communication in the Capsule, drugs were administered, usually a scopolamine-methedrine combination, popularly referred to as DDT ("Defence-Disrupting Therapy"). LSD-25 was also used, under carefully controlled conditions. Since it was first synthesized in 1943, LSD (lysergic acid diethylamide) had been used experimentally as a psychotherapeutic drug and in the treatment of alcoholism. It was, in fact, during trials at a California hospital (serving as a normal control) that professor Timothy Leary first encountered LSD, which he later promoted as a "mind-expanding" tool. The drug was enthusiastically adopted by the counterculture for recreation and enlightenment. Eventually most therapeutic uses would be abandoned because such treatment was not found to have lasting effects (although some researchers and physicians continue to claim that not enough research was done before

concluding that LSD was not helpful). However, in the mid-1970s the jury was still out on the drug's therapeutic potential.

Not surprisingly, the media found the goings-on at Oak Ridge irresistible, especially the Total Encounter Capsule. There were rumours of truncheon-wielding guards forcing crazed criminals to take LSD and strip, and then stuffing them into a cage. Concerned that sensational press could lead to closure of his project, Barker met the problem head on, inviting the media to Oak Ridge. Two reporters from *The Globe and Mail* agreed to participate in the Social Therapy Unit.

Joan Hollobon, the medical editor, came first. She asked to be treated like a patient, and was assigned a room on G Ward, becoming the first woman incarcerated in Oak Ridge! The only allowances made for womanhood were the curtains over her cell door. For two days, she participated in all activities, and was even assigned to a dyad.

"My Therapist, My Psychopath" appeared in 1967, and began, "Life crackles with tension and excitement on Ward G where 38 men—psychopaths, schizophrenics, defectives accused of killing, assault, rape—unite in the fierce give-and-take of self-therapy for the disturbed." The patients were praised for "pioneering a brave and exciting experiment in self-government and self-therapy," in which they displayed "individual responsibility, co-operation with colleagues and authority, and acceptance of rules reached by consensus."

Although she felt "embarrassed, like an eavesdropper," and conspicuous and awkward as the only woman, Hollobon was astonished how rapidly she began to feel truly a part of the community and to identify with the other patients. By the end of her stay, she had concluded that, no matter what the men of G Ward had done, she shared their essential humanity: "Have I not also felt like that?"

The following year, reporter Michael Valpy underwent a session in the Capsule with six patients, and wrote "Naked in the Box." The article was accompanied by another by Hollobon, "The Capsule is for Cracking Shells." Hollobon realized that the public saw the Capsule as reflecting barbarism and stupidity, but concluded it was really nakedness that aroused instant suspicion and anxiety. Barker, she asserted, was using the Capsule to achieve "an aim variously postulated by theologians like Martin Buber, psychologists like Abraham Maslow, and psychiatric researchers in North America and Britain": communication. ("Among Oak Ridge patients there has been such inability to communicate that many taking part in these extreme experiments once solved communica-

tion problems with guns, knives or tire irons.") The Capsule offered a safe place where the men of Oak Ridge could "dredge up from the depths of their minds—under emotion, or drugs, or both—the strangling shadows of the past."

Valpy begins his article with a question. He has been in the Capsule for twenty hours, and the smell is "a bit gamey" when Bob, 19, asks, "Do you really think people on the outside will understand about the Box?" This gives Valpy a focus. He describes his sensations in detail:

> The temperature is 92. Dead skin from our bodies had rubbed off on the walls in a grey and gummy film. I have slept for a short while on my stomach and when I raise myself I leave sweat pools washing in the crevices of the floor mat beneath my chest.

He introduces the occupants: "In this green world, seven naked young men: two who have killed, two who have almost killed, one who has stolen a lot, one who thinks a lot about killing himself, one whom the law says is free just now to walk the streets."

Valpy quickly overcomes the strangeness of nudity, and the feeling of loss for the little artifacts that comfort him: cigarettes, ring, glasses. He worries about his own psychological stability; he feels claustrophobic and cannot look at the six-inch-thick door of the Capsule. He feels apprehensive about his companions: "They are strangers, so I wonder how they will react to me."

At first the men are quiet and shy, and Valpy observes that from the observation post they must look "like dogs wagging their tails while they sniff noses."

The lighting in the Capsule is unshaded, and every fifteen hours will be flicked off and on as a signal to check the "score board"—pellets of soggy toilet paper stuck on the wall to indicate the degree of trust the occupants feel for one another.

Sent to Oak Ridge for hitting someone on the head with a hammer, Bob, "round-faced, a bit haggard looking," is aware of strong psychopathic elements in his personality. He thinks there is a little man living in his head who forces him to hit people and hurt them. Bob's experience in the TC has helped him, as "he is beginning to lose his grip on his psychopathy." No longer sure of who he is, what he feels, Bob has become very upset, which is a good sign. He now feels capable of recognizing his paranoid delusions when they occur. One of these has the Oak Ridge staff planning to murder

him, cut him into little pieces, and put them in small black boxes. A plane will land on the ground, the boxes will be flown to the far north, and dumped overboard.

Bob likes Phil, 20, dark, slim, calm-spoken, and trusts him: "At one point, a friendly gesture: he touches Phil's foot with his own. Phil has killed two people."

Nineteen-year-old Jim is "the quietest in The Box, more the introverted schizophrenic." He believes that when his mother visits, she perceives him as crazy when he feels sane, and sane when he feels crazy.

During the night, an attendant drops dexamyl capsules through a trap door. They serve as a stimulant, but communication remains difficult. Valpy feels uneasy revealing himself to strangers:

> After all, would I tell just anyone that I have had doubts about my sexual adequacy or hang-ups around my mother? Not by any rules of my Western society. Not unless I wanted to risk being thought a queer, a nut.

He is afraid that his is an inhibiting presence. There is too much small talk. Just before the men exit after thirty hours, one shouts, "I'm fed up with this crap." They shower and eat, and gather in the sunroom, five times the size of The Box:

> My earlier claustrophobia has become agoraphobia: fear of open places. I look at the others and they seem changed: smaller, timid, all the self-surety they may have projected in The Box melted away. We miss the womb. Weird.

The group returns to the Capsule, and Frank is injected with sodium amytal-methedrine to get him talking. Others receive dexamyl and dexedrine for the same reason: "DDT goes to work in 20 minutes." Frank speaks angrily of his crippled relationship with his parents, and of his problem relating to women. Because of awkwardness he was unable to win the affection of a girl, whom he saw on the day that he killed a policeman. Frank had once believed he was Christ and some patients were his disciples, but he has discarded that delusion. He speaks solidly for four hours, after which he remains almost immobile for the next five.

Freed from the Capsule, Valpy is the only one rewarded with a "uniform of the street." When he enters the sunroom fully clothed, conversation stops. "'Do I know you guys?'" he asks his former companions:

> I left The Box feeling pretty psychologically healthy. Inside, we had got to know something of each other, by little things like gestures, tone of voice, laughter. We had achieved a degree of togetherness, some kind of second level warmth.

Barker also invited filmmakers to Oak Ridge. *Thin Line* viewed the STU through the eyes of its participants, revealing that many were victims of parental abuse. The BBC sent a crew that produced a documentary, recalled by Barker as containing "lots of closeups of peeled paint and stuff like that." The CTV network shot the graphic, controversial *F Ward*, seen throughout Canada in 1969. It was largely the work of Norm Perry, hand-picked by Barker and given carte blanche. Boyd made its raison d'être clear at the outset:

> The staff here have developed some remarkable programs in recent years, and we think it's important for the public to see what's going on for themselves. Another reason that we are happy to let the public see this place is hopefully to alter their picture of the so-called insane criminal—I think they will realize that our patients are hard to distinguish from their friends and relatives on the outside.

Viewers saw it all—therapy in the sunroom, handcuffed patients, patients receiving drugs, and the Capsule in operation. They saw Barker in action, and heard him: "There is, we think, real hope that the patients here are breaking out of the psychological prison of indifference to the feelings of others, a prison which, to a greater or less extent, confines us all." They also heard from patients, who seemed, as Barker claimed, sensible and reasonable people.

Perry even filmed the management program, reserved for trouble-makers who refused to cooperate on the STU. Barker pronounced them reasonably cheerful, and "hopefully learning something."

In addition to displaying the inner workings of Oak Ridge to the media, Barker kept the medical community informed, by writing a series of articles for the *Canadian Psychiatric Association Journal*, beginning in 1968. The last appeared in 1977, and its opening sentence exemplifies Barker's forthright approach: "For the last nine years, on a regular basis, groups of naked mental patients have been locked in a small room for periods ranging up to eleven days."

Barker always shared the limelight with a co-author. Assisting with the first two articles was M.H. Mason: Patient—Intensive Care Unit, Ontario Hospital, Penetanguishene. Mason's own experiences

had made him an ardent booster of TC. While a university student, he had shot a man for insulting his girlfriend. Like many others sent to Oak Ridge, Mason did not believe he was sick, seeing his crime as an honourable act. Through involvement in the STU, he grew to understand the reality of his situation, and became a valuable associate of Barker's.

"Buber Behind Bars" explains that the reason for converting part of Oak Ridge into an Intensive Care Unit was "to mould a flexible and experimental approach around a few very basic assumptions." Based to an extent on the views of Martin Buber and R.D. Laing, these all had to do with problems in communication. To Barker and Mason, "in equating illness with an inability to communicate, a criterion was established by which the entire population of Canada was moderately crazy." Hence, the most helpful experiences for the mentally ill were acts of genuine communication, and the job of the STU was to remove barriers to direct encounters.

Barker's use of patients as therapists was a source of controversy. He believed the patient was in a better position than any professional to promote a direct, helpful encounter: he lived with his "patient," had no power over him, and was much closer to his mode of experience. The fact that patients were together at all times fit into Barker's plan for a total experience. Patients often complained that the STU "was in the business of upsetting people":

> Schematically, the program consisted of confrontation, anxiety-arousal, analysis, and support in committees, dyads, triads, and small groups, supported by community meetings, the use of demystifying drugs, and the feedback resources of video-tape equipment.

Barker was intrigued by the creative tension that seemed to breed friendships between people with different diagnoses. He claimed that the combination provided "checks and balances, softening the raw practicality of the psychopath with the dreaminess of the schizophrenic."

Barker rebutted charges that the program was overly permissive; on the contrary, he said, a patient was simply unable to coast, as almost every move was dictated by one committee or another, including "the penalties of his deviance." For those patients unwilling to participate in the program, Barker himself was not above using coercion. As they were bound to benefit, he considered this humane and helpful.

Boyd, some years later, explained his position on coercion. In response to the comment that you can lead a horse to water but you can't make him drink, he said:

> No, but you can tie him up at the waterhole until he gets thirsty. Which is what we did. I wouldn't do that to people on the street, but for people who have already offended society to a degree that they lost their liberty for years, I didn't mind getting a bit coercive psychologically (Personal).

Sociologist Richard Weisman later commented that "It is just one of the paradoxes of the Social Therapy Unit that the ordeal it required of its charges can be described as easily in the authoritarian language of the 1950s as in the emancipatory rhetoric of the decade that followed":

> It is an understatement to suggest that the ideas of Buber and Laing were deployed selectively. That communion could ever be achieved through compulsory interaction was explicitly antithetical to Buber's views on genuine dialogue (Buber, 1961). And Laing's own experiment with therapeutic communities—the anarchistic Kingsley Hall—was anchored in a philosophy that rejected the use of force or intimidation in any form whatsoever as an adjunct to therapy. But this is not to imply that the inclusion of these writings was merely strategic or insincere.... In the political equation that emerged on G Ward, the achievement of inner freedom was virtually unattainable without abandoning one's freedom to be left alone, to remain private, or to be protected against external interference. Thus was the paradox of humanism and coercive therapy resolved: Force was a necessary condition for freedom (286–287).

One problem engendered by the STU was that a patient released into the "real world" was often seen as "something of a nut," because he had become accustomed to speaking with complete honesty. One must relearn the social rituals and games to avoid making others feel uncomfortable. A student who had worked in the TC one summer found upon leaving that he was impatient with superficial talk, feeling as though he had left "a sane world populated by partly insane people, to go to an insane world populated by partly sane ones."

Barker claimed there had been definite changes in all ward members, though it was too early to judge whether these would be lasting, or simply the immediate product of the loss of privacy and the intense anxiety. He planned a research project to evaluate properly the results of the program.

The premise of the article "DDT—Defence-Disrupting Therapy" was that it was necessary to enhance the intense chaos of a patient's mind as part of treatment, making it more obvious to him that he needed help. A direct route to "loosening the rigidly implanted patterns of behaviour" was the combination of drugs known as DDT. As a research project, a thousand doses were administered to patients over a two-year period. The delusions that resulted, claimed Barker, revealed underlying dynamic processes. The drugs also softened the steely exteriors of psychopaths: "Many patients find it easier to develop concern for the psychopath when he is chemically cooled out and dependent, than when he is 'normal' and coldly aloof."

When the last two articles appeared in 1977, the STU was twelve years old. Its days were numbered as controversy continued, but this had failed to dampen Barker's enthusiasm over its heyday. Peggy Buck, Administrative Assistant at the Hospital, collaborated with him on "LSD in a Coercive Milieu Therapy Program," which outlines a four-year period during which thirty patients in the STU were treated with the drug.

Permission was obtained from the government to order LSD. It would be given only to a patient who expressed high personal motivation and whose family had consented. (Thus, "coercive" referred to the STU program as a whole rather than the use of LSD itself.)

In the early days of its use at Oak Ridge, LSD was administered within a medical model: the patient was kept in bed, accompanied by a psychiatrist, a nurse, and a friend. Later, the "responsible street model" was used, with the bed replaced by a mattress, pillows, flowers, incense, and acid rock music. In the former model the subject had been "led through an underworld of father and mother figures, death, guilt, violence and insecurity," whereas the latter allowed him to wander "through a usually pleasant but apparently equally imposed rose garden of pretty colours, fascinating sounds, and cosmic sentiments." Finally, LSD was given in a "non-directive model": the patient took it in the Capsule, where he stayed for two days, accompanied by a friend. The main task now

was to review those aspects of his personality which he himself felt were most troublesome.

Participants interviewed for the article reported that LSD had been beneficial and had given them important insights. Staff, however, did not note any improved mental state or behaviour, and the article concluded only that LSD seemed safe, and had proven helpful because of the high morale engendered.

During the six months that followed the launch of the Total Encounter Capsule in August 1968, nearly fifty patients volunteered to enter, in groups ranging from two to seven, for periods varying from one to eleven days. Many would return to the Capsule again; according to Barker, ninety percent found the experience helpful and useful.

Weisman's later research, based on documents and interviews, suggested a more divided response from patients to the Capsule and the STU as a whole:

> For [some patients] the process was so important that they would astonish the review boards before whom they appeared by preferring treatment under confinement to liberty—claiming that they needed to complete their therapy before they could ask for release. Still others would write tributes to the program, avowing that whatever deprivations they had endured, the results amply justified the means. For some, however, who did not want to change in the ways prescribed by the program, compulsory placement in the Social Therapy Unit was a continuing battle of wills against an overmatched foe—sometimes to be pacified by pretending to comply, other times to be resisted by evasion or outright defiance, but ultimately an ordeal for which the best possible outcome was survival. Just as there were testimonials by grateful expatients, there were also pleas for transfer and complaints about the use of force (285–286).

Barker was aware of the need for scientific evaluation of the Capsule, yet he resisted stabilizing it for research purposes because it was "too high a price to pay to fix a rigid format on so flexible a treatment facility." Besides, he had always disliked any reference to the STU program as experimental. Hence, throughout its nine years of operation, the Capsule witnessed variations: sometimes patients wore clothes, or tossed a plastic ball around, or listened to music. But always at the forefront was the basic objective of providing "a

treatment situation in which the patients could help each other to acquire an improved accuracy of perception of their own and others' feelings and ways of relating." Barker concluded:

> Designed initially as an attempt to overcome the problem of the escapist role-playing of the articulate psychopath, the greatest value of the Capsule is now seen more importantly as the way in which it provides a brief, very intense, but safe experience for a patient to look forward to or back upon as a bench mark during a lengthy stay in hospital.

Although often given credit for being an original thinker and innovator, Barker denied that programs on the STU were anything novel. He claimed only that he and his co-workers had done "a whole bunch of things that were being done elsewhere, and we did more of them and we did them more intensively and we did them all together" (Personal). *Together* was a key word for Barker:

> My philosophy was to work with the key power people—attendants and patients. It was like a politician negotiating. All the programs evolved with those groups, which were the power within the place. You had to work with these guys to make an idea fly with them, not because you had six degrees. Some people think raw authority allows you to step in and run a program. It doesn't! The patients wouldn't have gone in the Capsule if they hadn't been part of that evolving thing. These things evolved, with a lot of political sawoff. What will be acceptable to the attendants? To the patients? To me? I viewed my role as a politician in the system, who could bring in new ideas and let the people who had the informal power sort them out.
>
> The principle of listening hard to the guards who can shut the place down when they feel like it, and listening to the inmates, and mediating, I think is relevant to other programs. And when it's working right, the morale goes up and the security problems go down. What is the selling point to the guards? After five or ten years, I think it's clear to my guards that there's less worry about security because the patients are busy doing things that they're interested in doing. The guards don't have to worry about plans hatching and so on, and their morale is higher. One of the things I wonder about is whether you can sell this kind of program

> without devotion—I speak of it cynically now. At the beginning I was a true believer, I was the truest of the true. We were all going to get cured the next day, the next month, or the next year. And perhaps the people involved have to believe that, if you're on the cure model (Personal).

Barker resigned as Director of the Social Therapy Unit in 1972, although he would remain in the wings throughout the decade. In the words of psychiatrist Russel Fleming, "Elliott left because he only does things for a short time. He thought it was time to hand things over to someone else" (Personal). The time had passed when "it was sort of like the revolution":

> The patients knew what they had come from, they were close to it. The early pioneers in a revolution know what they've gained, they're excited about it, and excited about the process of change—but that wore thin increasingly. The guys who had been there for fifteen years in the old system had quite a powerful feeling: "We're breaking new ground here, we're doing great stuff, we're something." And they were (Barker, Personal).

The Ontario Hospital system was tightening up, and Barker anticipated a period of stultification. This was confirmed for him when a new administrator arrived:

> Dr. Boyd brought him along and I was showing him through the Social Therapy Unit and he walked down a corridor and he reached up on top of one of the grille gates and he wiped his hand along and there was dust, and he said—"This will change!" And I'm thinking, "Where is your head?" (Personal).

Boyd was disappointed by Barker's exit. They had worked well together, Barker dreaming up schemes for the STU, and Boyd finding money to implement them—and then keeping the authorities at bay! Boyd admired Barker for his "political sense to present his ideas at a psychiatric convention or get them published in a psychiatric journal before the newspapers got hold of them."

Barker was worried about adjusting to his new role as unemployed psychiatrist, after the excitement of the STU:

> I was bad. I worked eighteen hours a day. I would come home exhausted. I did not do with my daughter what I preach now that people should do with their children.... I didn't think I could get unhooked off it, being always the centre of the universe—but I did. And only with considerable reluctance—when we ran out of money!—did I start back at all (Personal).

Upon leaving Oak Ridge, he returned to his farm, cut a thousand fence posts, and enclosed his property. Later his work took another direction. He had come to believe that while the backgrounds of psychopaths were as different as their crimes—some were deprived, others privileged—there was a common denominator: "the absence of a close relationship with a loving adult during the first few years of their lives" (Dean). He therefore founded the Society for the Prevention of Cruelty to Children, dedicated to ensuring that every child receives the love and attention needed to blossom into a caring human being.

> I settled on the society's name because I can't imagine a greater form of cruelty than rendering a human being forever unable to trust and give and receive affection. If, 50 or 60 years ago, we had developed an AQ or an EQ—an affection or an empathy quotient—instead of an IQ, I think we'd be a much less violent society today. We all want to love and be loved (quoted in Dean).

He commented later:

> What has driven me was the experience of knowing and liking a lot of psychopaths, and having a very real sense of their limitations. It can be enormously sad. They can look supernormal and be wonderful people, but when you get close to them you see they look with puzzlement at people who love or are able to trust other people. They're kind of incredulous about it. They don't know what it means. It's an absolutely devastating illness—it's also rampant. I had been getting the idea to beat the drum for better care of children in the first three years. I think that's when psychopaths are formed. I think you can't treat psychopaths, we don't know how to treat them, you can't fix them. It's a very serious illness even though many psychiatrists deny it's an illness (Personal).

Later research would suggest that the TC, and the Capsule in particular, were not effective treatments for the patients they were designed for. Nevertheless, there are few who would question Barker's sincerity, or his strong sense of justice. Or that, above all, he tried to do *something*:

> I've always thought that the critics of the program basically believed in the concept of humane warehousing—you just put people into prison and you don't do anything. Well, that's bullshit. If you go in there weighing 120 pounds and looking cute, you're going to get raped, and you're not going to be able to do anything about it. You may be sentenced to three years, but you're not sentenced to get raped or to have all your stuff taken away, or sentenced to be under the thumb of the sickest lout in the place—which is a fact of prison culture. Civil libertarians don't seem to care about that.
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> You have to grab hold of that whole system and straighten it out so that the community is even and the weakest little guy can indict the toughest guy in a ward meeting and it's safe for him to do it. I think that's what was good about the program. What the civil libertarians say is, "My God, you're locking these people up, you're dragging them to meetings, and you're violating their civil rights." But humane warehouse them in a prison and close your eyes—and that's just fine. Society wants Joseph Fredericks [sentenced to life in prison for the abduction, rape and murder of an eleven-year-old boy] to get stabbed in prison, and everybody's happy! (Personal).

There was a lot of capacity for love, and caring, even in a maximum security bug house. They weren't people with horns on their heads; they were real people doing real things with each other. More real than you'd find on the street. At times when the community was running well there was more caring, loving kindness and looking after your brother than there is in the external world (Barker and Gifford).

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Turned On; Locked Out

I think Canadian psychiatry went farther in Boyd's era at Penetang at looking at who the person is than in any other place. The STU was one of the great experiments in psychiatry. To break through some of the traditional views was an adventure, and it was really a privilege to be part of the whole thing.

Dr. Gary Maier, 1995

We were seen as the cold water on this stuff, and that was probably true. But I don't think it was just us—it was the times.

Wayne McKerrow, former administrator

During the 1970s, the pioneering work being done in the Social Therapy Unit at Oak Ridge went even further, before crashing to a halt amid dissension.

Dr. Gary Maier

When Barker resigned as director of the STU, his place was taken by Gary Maier, whom Boyd later described as a very brilliant young fellow. Maier graduated in medicine from the University of Western Ontario in 1968, and became interested in psychiatry during a rotating internship. He enrolled in a Career Line program that offered financial incentives for working in an Ontario Hospital, intending to buy his way out at the end. However, when hospital superintendents came to a Career Line Day:

Dr. Gary Maier, 1990s

Boyd left a lasting impression on me. He had a calm presentation for very exciting material—he could talk about murder and rape and insanity without getting dramatic.

I went to Penetang and I met Boyd, and Barney Eades, who was the Psychiatric Unit Chief on the Activity Therapy Unit, and Elliott Barker. Barker and I became old friends quite quickly. By the time I had supper at Boyd's, I was committed to come to Penetang for my fourth year, my elective year.

Maier became acting director of the STU in July, 1972, under Barker's mentorship.

When I stood outside Oak Ridge, I said, I want to know everything that goes on in this building. I don't want to leave until every secret has been told. And there weren't many that were not told to me.

What would the most dangerous guys in Ontario be like? We had some in Penetang, and my concern was not that they would harm me—I was only hit once, and it was my own fault—and I never feared that somebody would attack me from behind, because I encouraged face-to-face confrontation. A lot of guys threatened to kill me; one said he was going to stab me in the heart with a pencil. I faced some difficult situations, but I just got too smart-alecky with the guy who laid a beating on me. I said something, and I knew, uh-oh, I'm going to get it! I was too close for him to harm me—eyeball to eyeball—and when he started to hit me I fell into him, and there were people there so I didn't get hurt. But it was a lesson on how to gauge my verbal stuff, and I must have learned it well enough because I never was assaulted.

The first week I was there the Review Board was meeting, and for the first time they wanted Elliott to justify why he was not releasing a patient. The onus before had been on safety; he had to argue like mad to get people released. A patient had done an end run

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around Barker and had gone on a hunger strike. I watched Elliott make a forceful pitch to m'lord, and—we lost! Elliott took me aside and said, "The times are changing here, so you've got to be on your guard."

I knew after a couple of weeks that I'd be able to manage, and that I liked it. On Wednesday nights I would go to Barker's farm, and we would talk about issues, and I found it exciting. I got a chance to know him in his own setting. He burned wood as a source of heat, and one night while we talked a chicken sat on his head!

That year Barry Boyd was the President of the Ontario Psychiatric Association. For the first time they had decided to have resident members, and I was the first elected to their Board of Directors. It meant that Boyd and I went to national meetings together. He was also Chairman of the Canadian Psychiatric Association Committee on the Insanity Defence, and I was on that committee. So I got elevated in my career right to the top in a short period of time, and was talking to the senior people.

According to Gord Byrnes, then an attendant and later assistant administrator,

Gary brought a fresh approach to therapy; he too was going to treat the psychopath, but in a different way. He used the Capsule and the sunroom more extensively, and moved the therapeutic community up to F Ward where they were located. There were forty-five patients and only thirty-eight rooms, but some would be in the sunroom all day.

Maier revamped the system Barker had brought in of patient government by committee, designed to teach patients to solve psychological problems. In the committee system, a clarification committee would identify a problem, and, if action was needed, refer it to the treatment committee or the sanctions committee. The committees were coordinated by the staff-patient liaison committee, and the crisis committee acted as a sort of patient police force.

Maier: So with those committees in place, you just needed five or six patients who knew what they were doing as chairmen, and they ran a darned good system.

That group of patients had run the committee system in all its perms and combs, and they wanted to do something more sophisticated. With my coming they took the opportunity—in fact, Barker had primed the pump—and we created the tribal system. Essentially, there were three tribes, and they acted as the clarification, treatment, and sanctions committees. You needed a two-thirds majority to get things through, not just fifty-one percent. And the patients knew it was harder to manipulate; if you had a smooth-talking psychopath, he couldn't have as much power without running into the other powerful patients. During a two-month period we rewrote all the rules, in what the patients called the New Testament, which described how the tribal system would work.

The patients would come in on H Ward—Get Together—for assessment. It emphasized the pupil/teacher paradigm, and was rule-oriented. Then they went to the first all-day Therapeutic Community on G Ward—Talk Together—run according to the committee system. At the end of every cycle of three months or six months we would collect the most motivated patients, who were farthest along with therapy, and sequester them in F Ward—Be Together—which had the tribal form of government, their second community experience. Here the person as an individual was stressed, and there was a concerted effort to discover the self in relation to the freer community organization. The program on E Ward—Work Together—had the patients working in five or six different shops. We ran that with a central committee, very much like a communist model. The tribal system seemed to run very well, and after one year Boyd formally offered me the job.

Maier continued the use of mood-altering drugs, including LSD.

I used LSD in a different way from Elliott. He used it as a defence disruptor; people had defences, and you would sort of knock them down with the drugs. What I said was, We're giving the patients this drug so we can open the door from the inside; we won't have to knock it down. And that was the change in metaphor in the system. Elliott was a sort of assertive guy; he wrestled in university, and had a natural way of being able to grapple with somebody and overpower him—obviously gently and caringly—but that was his style. Therefore, a battering ram approach to drugs not only fit his style, but it fit the attendants' style—they liked the idea that these guys were kind of knocked out. Since I had done an LSD trip as part of

my residency program, I knew I wouldn't have wanted anybody running at me while I was on that drug. So I shifted it to open the door rather than knock it down.

I applied to the Canadian government for more LSD, and in 1973 they sent me two hundred 100-microgram vials. I used it a number of different ways, but ultimately it culminated in the LSD program, which ran in mid-1975. Twenty-six patients paired up in dyads, and all did a 300-microgram LSD trip as a rite of passage into the Tribe. The patients studied for this for two months, and we moved them up to F Ward only when they were ready. That was the program I thought had the most merit, and the patients thought had the most merit—but the attendants got worried.

The goal of an LSD trip was to have the most positive experience of your life. It was based on this idea; when I got there Barker said, "Nearly all the patients in this program are the throwaway people society doesn't want. So just about anything we can do is going to be positive. The next thing is, they're tattered." Today we would say their self-esteem was low. They'd been abused as kids and they were just handing on what they'd found. He said, "Our personalities are set in concrete by the age of two. One of the things we've got to do is, if we can't melt it down, to blow it up."

The time from my arrival at the Hospital to the LSD program was a slow, steady evolution, of me coming to understand a particular way of letting people be together. I took all the best things that Barker and the attendants had assembled. The committee system still ran on G Ward, the tribal system now ran on F Ward, and I piloted different ways to let people open the doors from within. In that process, I ultimately guided sixty-seven LSD trips, I gave over five hundred sodium amytal trips, and I was giving people sodium amytal, scopolamine, and dexamyl/Tofranil to the tolerance of the system. In other words, I was quite prepared to let people explore themselves with the aid of drugs. There were times when everybody on a ward who wanted to—I didn't force medication on people—would get it in turn. I didn't give everybody the medication at the same time, because I had to have some patients to care for others. We ran a three-day session that was really spectacular, before the LSD community; every half hour I did another sodium amytal. People would be down for about three hours, so I paced it so the guys who were coming down would be there for the guys taking off.

We had people who in prison would have pounded you out, but on the LSD program we got them all paired up in good positive dyads. We kept building trust, and then allowed the exploration of the outer world.

Len Tugwell, attendant: Maier was far out; I liked him, but he was way off in the distance. We used to take the patients right back to where they were lying in the womb, all curled up. That man could hypnotize people. Gary Maier used to spend hours and hours—unbelievable hours—in the Capsule and outside the Capsule. We started giving scopolamine once, and we were going to give one every forty-five minutes. We got one guy going, and he just nicely got into it, and before he was done, we were getting one about every seven minutes. And we had thirty-eight patients on scopolamine. There were only Maier and I in that sunroom with thirty-eight patients—but I had damned good staff at the gate though! Nobody's ever done that, and they were right out of it. But they all supported each other. He said that would happen and it did happen; he always maintained that they would support one another, and he proved it.

Boyd, too, commented later that Maier's ideas were even further out than Barker's already unconventional approach:

He was into some of the Eastern philosophies and *The Tibetan Book of the Dead*. That stuff could be dynamite if certain people got hold of it—they could say we were trying to brainwash people with religious ideas, but we just thought it was something patients could share with enthusiasm together, as they shared their feelings and talked. Once he had the whole ward sitting around, staring at their navels going *Oooommmm*. I had to make darned sure if the Minister was visiting I didn't take him in to witness that scene!

Yet Boyd supported Maier, probably because he believed the program was working well. The Social Therapy Unit received nationwide recognition in February 1977 when a parliamentary subcommittee on the penitentiary system in Canada visited Oak Ridge, following a visit by a team of medical professionals sent by Arthur Maloney, Ontario Ombudsman:

This is an exciting programme which has the hallmark of being right—as an expert skater looks right, or the final model of the DNA molecule looked right to Watson and Crick. Here,

> the impossible is apparently happening—psychopaths are being treated with success... the hospital attracts attention, and observers from around the world. We were satisfied that the men we saw and had known prior to their admission to the hospital, had benefited greatly from the S.T.U. experience. We were quite sure that the program itself was of considerable benefit not only to the patients, but to the hospital as a whole and to the country ("Ombudsman's Report").

One month later Boyd was invited to Ottawa to speak to the Sub-Committee:

> Dr. Barker and I became known as "The Hanging Psychiatrists" awhile back. There was an article in *The Globe and Mail* with our pictures saying, "Psychiatrists Favour Hanging," and I got more congratulations from that article, from the people who just read the headline. The people who read farther down could see that we were talking tongue-in-cheek, that the minimum 20-year incarcerations were an utterly hopeless situation.... That is what we really meant. The point is so important that we have refused to accept some patients at Penetang who have had these sentences, and my argument has been, what is the point in trying to cure him? We had one, in particular, where they wanted us to take off his testicles and, miraculously, cure him of his problems ("Minutes" 5).

In their report to parliament, the sub-committee commented on the impressive results of therapeutic communities at Oak Ridge ("Report"). They noted two remarkable things: a complete absence of hostility ("The Oak Ridge Experience simply drains away the poisons that build up inside men in penitentiaries"), and the acceptance of individual responsibility for past behaviour. Concluding that "the social therapy technique developed by the Oak Ridge Division of the Ontario Mental Hospital at Penetanguishene is the most promising known for assisting offenders in self reformation," they called for its use in both maximum and minimum security institutions and suggested that new institutions should incorporate the small, self-contained units needed (122).

Yet by that time, the Oak Ridge Experiment was already nearing its end.

Maier: The LSD Program of 1975 went so well that we tried to run a facsimile of it with the last LSD during 1976. The trouble was there was only enough for twelve more trips, so twelve guys volunteered to guide twelve others. But it wasn't the same; the system was crowding in on us. Halfway through, because of my restlessness and reading the signs, I decided to take a year off. I was feeling the lack of support—I didn't have the attendants on my side—and all that took its toll.

Maier left in the fall of 1976. He spent four months in India at an ashram, where he was invited to stay on as a group leader. However, "I realized that if I didn't go back to the West, I'd be avoiding a lot of me." He returned in the fall of 1977 and asked for his job back. Boyd agreed, after consulting with other medical staff.

Maier: We spent a lot of time trying to regroup; there was a horrible thing in the system about possible beatings by staff on H Ward. When I came back it was like we were living a lie; the idea of open and honest communication—a standard phrase—was no longer open, and no longer honest. There was a lingering, unhappy peace, where nobody was talking, but after a month things related to the Social Therapy Unit were getting plugged in, and we were digging out from under the allegations about beatings. I actually thought it was on track, although it was very risky. However, at one point the staff thought I was going to put therapy back in either too quickly or the wrong way, and they got angry.

Dr. Russel Fleming: Maier irritated a lot of people. He just trucked over people at times with his aggressive style, as opposed to Barker's smooth charm. Barker was prepared to live with a lot of things for the greater good of programs surviving and developing, even if there were some rough edges. Gary knew that, but wasn't prepared to wait, or to live with that kind of indirect way of doing things.

Maier: I tried to work with the attendants, although I had my own impulsivity, and I didn't see them as so instrumental in the work force as Elliott did. He did something really brilliant when he realized that a lot of these guys had been in the army together; they had fought together, had natural allegiances, and knew authority. He set it up like the committee system, only he did it with the attendants.

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Byrnes: Maier had a team that had a nurse, a social worker, and the area supervisor, so that's four people. They made all the decisions; the attendants weren't part of it. We were low-lifes, and he didn't want us or anyone else that wore a uniform. And the attendants, of course, got their backs up, and hated him in return. He would practise yoga, or some form of it, and would sit in a lotus and hum. That drove the attendants crazy! He would sit in the sunroom, with all these patients around him on the floor. And he took all the furniture off the ward. No chairs. The patients couldn't even sit on a bloody chair! And he expected us to sit on the floor with him. They all had their cushions, and if they were going to a group, or were just going to the sunroom to watch television, they took their cushions. Every patient you saw in the corridor had his cushion under his arm all the time. Because there wasn't a chair! We never did understand the purpose of that. After a shift we'd go to another ward and grab a handful of stacking chairs and take them back to watch television. And the patients would get mad because we had chairs and they didn't.

There was talk about the drugs that were used in the farmhouse where he was living, and all the different people who would float in and out. He had a terrible reputation that way. The attendant staff are similar to correctional staff in attitude. Their duties are more or less similar—or were in those days. The average attendant had short hair, had a drink after supper with the wife, and wouldn't even think about drugs: "Get up early and we'll go fishing," or "I'll meet you after church for a tea." Strictly country rural stuff. So if you get someone in who is supposed to be influential and a role model, but is openly doing drugs in front of you and giving them to the patients in the name of therapy, it didn't stand very well with the attendant staff. He had a couple of strikes against him.

He did a lot of strange things, a lot of really strange things! Bill Crawley had just taken over as chief attendant [when Maier arrived]. Crawley was as hard as nails; this guy was rough around the edges, like a rasp. Tough, boy he was tough! But he was a softy too. If you treated him well, he treated you well too. Maier came walking down the mezzanine corridor, and he had a bouquet of roses. He gave a rose to Bill Crawley—and he kissed him! Crawley stepped back, and you could see him drawing his arm back like he was going to

piledrive him, and Maier just kept going. So Crawley was just kind of struck there, like he was paralyzed, turned to stone. He threw the rose down, and he swore at it. I was at the other end on B Ward watching this happen, and thought, *Oh God*. Crawley was still spitting when he went by, and he says, "That man is crazier than any patient in here." That's the kind of thing Gary Maier would do.

Vernon Quinsey, psychologist: He wanted to conduct treatment, but he didn't have his senior attendant allies lined up in the way he should have, and they brought the whole thing down. The ATU people hated that program, because of the way it started; basically they got drummed out. So the union would have clicked right in. There were concerns about having many treatments going on simultaneously; they were doing alcohol treatments and drug treatments. Len expressed reserve about that, and Gary was curt with him and said, "I'm in charge." This attendant thought first of all that the situation was dangerous, and secondly that Gary shouldn't speak to him like that. He'd been loyal to this guy, and here was this guy dumping on him. So there was disaffection at the senior end of the attendant series on the Social Therapy Unit.

Maier: It started to come apart, and it came to a head this way. It was the old-side attendants who locked up the place, the same ones who had fought Elliott tooth and nail, and been sent to the Activity Therapy Unit. They became more empowered with the rise of the union. They had waited fifteen years.

According to Byrnes, the trigger was an investigation of a report of illegal drugs on the ward, which he says Maier sabotaged by warning patients.

Byrnes: The union president was more upset than anybody; he went down to the chapel and had an impromptu union meeting, and we decided to keep the place locked up until they got rid of Gary Maier and his team. Of course Barry Boyd became involved; he met with us, and when they explained to Boyd what had happened, he instantly realized he couldn't support Maier, because Maier was supporting illegal drugs. So he agreed to pull Maier out of the Hospital, take him down to the Regional, and reassign him. He made Doug Tate the acting unit director, the first non-medical unit director we ever had. He wasn't there very long, but he was the first. And we agreed to open up the building again. This all happened in the

same day; it was just a matter of a couple of hours. That's how we got rid of Maier.

Maier: They came on like Nazis, and locked up all the patients. I had a lot of patients who had just done drug trips, as we were starting to put the old model back in, and they were raw and fragile and crying.

As five union guys were going from ward to ward I encountered them, and I allegedly assaulted the union president by putting my finger on his chest and giving him the finger in the face.

Why did they lock me out specifically? I think I represented all the terrifying kinds of instability, and the lack of support for them, and putting them at risk. They needed to get back in control of their world, so they fell lock step in behind the union management.

After a few months at the Regional Division, Maier left for the United States, continuing his career at the Mendota Mental Health Institute in Wisconsin. In Fleming's view, "In the few short weeks that followed the crisis, the thing would have been salvageable.... We could have gotten the warring sides together and, with some adjustments, the attendants and Gary could have lived with the compromise.... But the decision, made largely in Toronto, was that he was a maverick and a trouble-maker, and therefore had to be excised from the situation." The STU program continued under the leadership of Dr. Daniel Luciani. However, according to Fleming, the team felt itself increasingly at odds with the nursing staff, and believed that "administration would support the attendants and not them in times of conflict."

BOYD RETIRES

Meanwhile, in March 1978, Boyd retired from the Hospital, though not from professional work. He had been recruited to collaborate with the Federal Department of Justice on a feasibility study on proposed reforms to the criminal system. At a farewell gathering, Minister of Health Dennis Timbrell recognized Boyd's international reputation for his accomplishments in the mental health field, and Barker praised his vision, innovation, and courage. Moricz, who would also leave the Hospital in 1978, presented the medical director with a flag for his beloved boat, inscribed "MHC Penetang" and bearing Boyd's trademark—a huge cigar.

In his speech, Boyd claimed his main achievement had been to recruit extremely competent staff, to develop strong professional departments, and then efficient interdisciplinary teams.

> Our staff-patient ratio has risen from 0.4:1 to 1.1:1, but the average of our mental hospitals is 1.8:1. Many hospitals without maximum security have more than double our resources. We all realize that our Ministry of Health is in a financial squeeze, and that money must be saved, but does Penetang have to be at the bottom of the ladder?
>
> ...Oak Ridge has a splendid security record. Two escapes in twenty-five years. One-tenth the usual suicide rate for such patients. No homicide, hostage or riot. The treatment programs are world famous.
>
> ...If we had a serious episode, I know what would happen. Head office would have to suspend or fire the Administrator and the Medical Director. They would send in an independent investigator with a Ph.D. in something esoteric. His recommendations would get immediate action, and they would have a remarkable resemblance to what the local administration has been requesting. Let us hope that it doesn't happen this way ("Retirement").

Indeed, within two months Ombudsman Maloney sent three investigators to Penetanguishene, all doctors. He was miffed at having been refused entry into Oak Ridge during the lockout. Maloney echoed Boyd's complaints about understaffing and underfunding:

> This hospital, which should be the flag ship carrier for the Ministry of Health, has recently had its funds cut to below the acceptable level. We recommend that Oak Ridge be financed at the top of the scale and not at the bottom as it is at present ("Ombudsman's Report").

A New Regime: Stokes and McKerrow

Boyd and Moricz were replaced by Dr. Ronald E. Stokes and L.W. McKerrow, "appointed to the Mental Health Centre Penetanguishene to apply a caretaker administration and a mandate to subdue the disputes between management and staff" (Susan Barry).

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Dr. Ronald E. Stokes (left) and L. Wayne McKerrow

McKerrow had come from the Lakeshore Psychiatric Hospital, where he had also served as administrator. He and Stokes began work in Penetanguishene on the same day, June 1, 1978.

McKerrow: The day I went up, there was the appointment of the new senior psychiatrist. Everybody at Penetang thought that Ron Stokes and I had worked together; in fact we didn't even know each other. He had accepted the position before I did, and he wanted to see a change of administration; that was one of his requirements. And I was concerned. What if he didn't like me? Would he want another change of administration? So Ron and I spent a long time on a long-distance phone call, and he satisfied me that he wanted an administrator, that he wanted to do more of the clinical stuff. I still had some concerns when I went in that Ron would be powerful, and he was! He was a full university professor and he had worked at the Clarke. We made a commitment that we'd look like we got along; the fact is, we got along very well, and I have the highest regard for Ron. When Ron said something was going to happen, it was going to happen, and the same thing with me. In a place like Penetanguishene you have a lot of critics outside. The press doesn't like you, nobody likes you! If you don't have strength inside, then you really have a lot of problems.

SHUTDOWN

The most obvious problem facing the new team was the continuing tension in Oak Ridge. The crisis came in the summer of 1978:

McKerrow: There was tremendous conflict in the Social Therapy Unit, and the breakdown in that unit led to the lockout in Oak Ridge, which led to my appointment. They had physically removed the Ombudsman out of the building, and he was a little perturbed. So when Ron Stokes and I went up, there were terrible labour relations between the union executives, and there was almost a complete breakdown between the blue shirts and the professional staff. Stokes and I and the director of nursing went up and talked to them all, and we said, "You either have to fix it, or we'll have to take action." We told them we didn't know who was right or wrong, and we didn't care. Everybody said it was getting better, but then we heard about an incident which made it clear that nothing had changed—in fact, it was worse. So Stokes and I went up and moved all the professional staff out of the unit. And we left the attendants in charge. We couldn't remove the attendants. There is one thing about administrative decisions; sometimes they're not hard because you don't have any choice! Everybody was running around chasing their tails. So we decided to act—it was brave, and luckily it worked! But what if there had been a death that night? OK, where was I? No doctor! No nothing! It was high risk—that was probably the toughest decision, but Stokes and I never looked back. He came in and said, "What are we doing?" And I said, "We're taking them out." And he said, "We have no choice." So it was between the two of us, and we would have backed each other up to this day. You just did what you had to do; you didn't do what you wanted to do. We took the unit apart, and everyone was shocked; there were people shocked beyond belief that we would do that. Two or three were as angry as I have ever seen; they felt we had destroyed the treatment in there. And undoubtedly some of that is probably true. It didn't make any difference; there was a total breakdown between professional staff and the blue shirts.

McKerrow commented later that another factor in the decision was that changes to the Mental Health Act (which he had helped to draft) introduced requirements for consent that made it impossible to run programs in the same way. McKerrow's action, supported by Queen's Park, is variously seen as bold and effective, or as a spineless surrender to pressure from the attendants.

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Barker was asked to return and run the STU temporarily. He agreed, on condition that Peggy Buck be assigned to work with him as unit coordinator. During his months as interim unit director, Buck "singlehandedly did an enormous amount of work—she was the liaison with the Review Board, and with all other institutions in the province, she knew every patient—the nature of their charges, and where they went afterwards" (Quinsey). She often remarked, "It was always Boyd, Barker, and Buck." Barker issued a memorandum stating that he would be available only before noon, and all business was to be communicated to him through Buck or Area Supervisor Bill Salisbury, who would decide whether to act directly or to refer the matter to Barker. "With luck, this streamlined system will be so damned efficient that I will begin to bumble around the S.T.U. shortly after 10 a.m. gossiping with everyone, confident that matters that will get me and others into hot water have been dealt with" (Barker, "RE: Lines"). Barker was able to exit once more when Dr. Pedro Delucas was appointed director of the Social Therapy Unit in 1979. However, Delucas soon requested a transfer, and was replaced by Dr. Julia O'Reilly in 1980.

The Social Therapy Unit continued until 1986; however, it no longer followed the therapeutic community model nor used such techniques as the Capsule. The Hospital "reverted back to its practices of twenty years earlier, relying heavily on medication and electroconvulsive therapy to control agitated patients, and leaning towards offering secure custody more than treatment" (Fleming, Personal).

Maier: Could the Social Therapy Unit have gone on forever? The answer is *No*. First of all, we were losing our political protection, which was Barry Boyd; he was retiring, and while the system gave him a very wonderful sendoff, if he had not been retiring they would have been very forceful with him. Boyd came in '60, and he got it all the way to '78! You could not keep a thing like that going in a linear progression, because there is a season to all things. That sort of program could not have continued because we're now training people to do science. We're not training people who will creatively discover the people with mental illness; they're going to study the signs and symptoms of mental illness, and the impact of drugs.

What happened on the Social Therapy Unit was that people got past all the crap of family, education, the label of their crime, the label of their mental illness. As the promise of that process was possible, we went right to God. We had people fall in love with

God; the LSD acted for some people as sanctifying grace, it acted to give them a vision. I used to say about the Capsule, "This room is the safest room in Canada;" it's a room within a room, in a building that won't move around, and it looks like you're trapped, but the way out is through the eyes of the other people here, and you'll see forever. You can see infinity in here.

You can't institutionalize that. I knew that the vision of Boyd and Barker and myself had come to the direct contact of one person with another unimpeded by pathology. And when that happened, they were free. And it didn't matter that they had bars on the windows; nobody had their spirits. Now anybody who tries to codify that fails! When the organizers come in, then the light goes out, and that's what the attendants said the following year: "The light is out there." But the light was on for a while!

The light is out in most places, especially mental hospitals and prisons, nearly all the time. There is no magic, nobody sees anything. They're all blind, and they're killing each other with dishonesty. We made a really fantastic attempt to break through to truth, and by golly I think that there were times in Barker's day and in my day when we had small groups of people, or a whole ward—or even a whole program—for a period of time just—pure.

Research and Results

But did the STU program work? This was a question that was answered intuitively in the first several years; Barker, Maier, the Ombudsman, other staff, and many patients all saw clear evidence of real change. But it was not until the 1990s that researchers at Oak Ridge produced actual data on how patients fared.

Although not formally initiated until January 1975, the Research Department of Oak Ridge, located in the Active Treatment Unit, had been running since 1971, with the encouragement of Boyd. Before that point there had been few program evaluations and follow-up studies of released Oak Ridge patients. In particular, there had been little study of child molesters, and there was great uncertainty about what treatment to offer them and what criteria to use in deciding whether to release them.

Initial research was hampered by lack of funds and staff. However, when a new psychologist arrived at Oak Ridge in 1973, chief psychologist Manfred Pruesse urged Boyd to alter Dr. Vernon

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Quinsey's position to research psychologist. Quinsey had joined the staff in 1971 as clinical psychologist, and directed the behaviour modification program on the ATU. On his own initiative, he had also been developing research programs. By the end of the first year there was a research program that focused on prediction of outcome among released patients, evaluation of ward-based behavioural interventions, and the assessment and treatment of child molesters. In 1990, a Selected Chronology of Publications Pertaining to Oak Ridge (Rice and Harris) contained more than fifty articles by Quinsey.

The follow-up studies of the STU were carried out by Director of Research Marnie Rice, research psychologist Grant Harris, and research psychometrist Catherine Cormier. When Rice began working at Penetanguishene in 1975, she was impressed with the integrity and apparent success of the program, and felt it should be evaluated empirically. However, the program was shut down before the study could begin. Thus, the studies were carried out retrospectively; since it was not possible to assign patients randomly to different programs, patients who had participated in the STU program were matched by age, offence, and criminal history to people who had been in prison and had not received treatment. The researchers looked at the outcome after an average of ten years in the community or a low-security treatment facility. How many committed new offences? In particular, how many committed violent offences, the most serious concern for society?

Initial results were disappointing. Fifty-nine percent of the STU graduates failed, 40 percent through violent recidivism; slightly better rates than for untreated subjects (68 percent and 46 percent), but not much. However, the researchers reexamined the data. The program had been designed especially to treat psychopaths; perhaps it had been more effective for them. Here the results were startlingly different from expectations. In fact, psychopathic subjects had done significantly worse than their untreated counterparts, whereas the reverse was true for nonpsychopaths. Of those identified as psychopaths, almost 80 percent of the STU graduates had committed new violent offences (compared to just under 60 percent for untreated psychopaths). Why? One possibility was that the STU raised patients' self-esteem; unfortunately, they "may have learned to be more self-confident criminals who could maintain high self-esteem while committing antisocial acts" (Harris, Rice, and Cormier).

Also, it is possible that, whereas the nonpsychopaths in the program learned how to be more empathic and concerned about others, the psychopaths simply learned how to appear more empathic. They used this information so as to better manipulate and deceive others, whereas their counterparts in prison learned more about ways to commit crimes without being caught. In the absence of any true empathy, the better manipulation skills of the treated psychopaths allowed them to use and abuse others (in both violent and nonviolent ways) (Rice, "Violent").

Dr. Marnie Rice

Becoming more empathetic was a common goal for patients in the STU. Harris, Rice, and Cormier speculate that the nonpsychopaths actually did gain empathy; the psychopaths, however, learned the cognitive aspects of empathy (seeing things intellectually from another person's point of view) but were unable to learn to *feel* empathy—the aspect that would inhibit a person from hurting another.

Whatever the reason, Rice and colleagues' research suggested that this program, created with so much optimism and carried out with so much passion and intensity, may have brought insight to the people it was designed to help; however, it made these men more likely than ever to be violent.

After the Debacle

Although it would never be as innovative, Oak Ridge continued to experiment. Peter Spohn, a reporter for the *Midland Free Press* (and great-grandson of Dr. Philip Spohn, the first superintendent), wrote of the introduction of pet therapy: "Animals, rabbits, and dogs are brought in for the patients, mainly those who are mentally retarded, to see and touch, something they haven't done for years."

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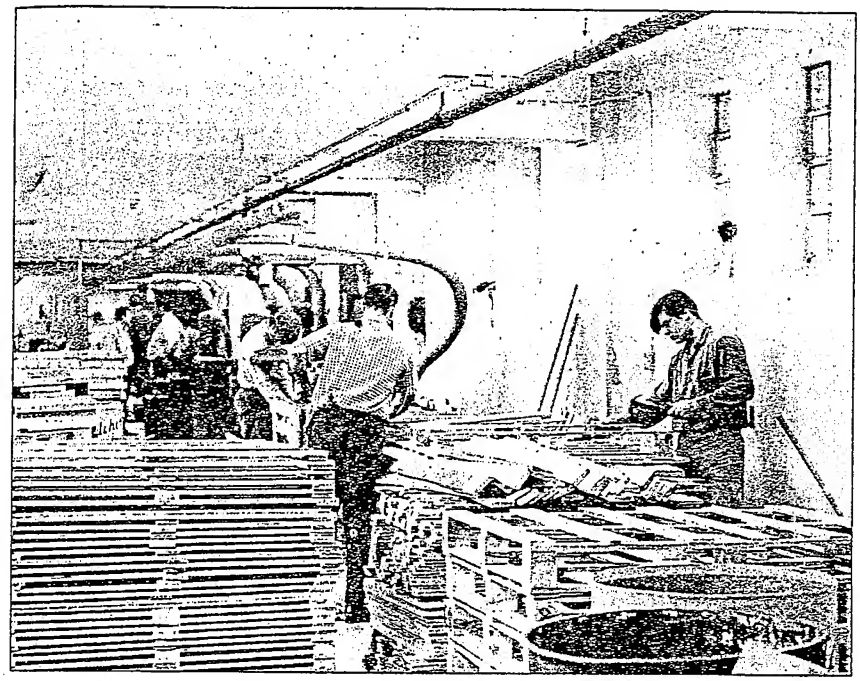

Industrial therapy, Oak Ridge, 1970s.

An initiative spearheaded by Terry Knight of Vocational and Recreation Services was designed to attract more patients to participate in treatment. Many patients preferred the work programs—cleaning, operating the canteen, videotaping, typing, printing, or producing merchandise in the workshops—because they could earn money. Under the new patient incentive program, patients could be paid for cooperating with treatment; payment was tied to points earned on weekly evaluations. One attraction was that the program would not require additional funds.

Locked Down Again

The dismantling of much of the STU did not bring permanent peace to Oak Ridge. In 1979, Oak Ridge attendants once again staged a wildcat strike in the form of a lockdown, during which they confined patients to their cells. They wanted to join the correctional bargaining unit within the Ontario Public Service Employees Union (OPSEU), which would give them higher pay than other hospital

attendants. Management and most clinicians objected that Oak Ridge is a hospital not a jail, and this affiliation would suggest that Oak Ridge attendants were more akin to prison guards than to caregivers.

The strike was to begin on a Monday, and managerial staff were ordered to report for duty the night before:

> We were told that the employees of Oak Ridge were going to walk off the job at 7 the next morning. We were supposed to sleep overnight in the administration building, and I ended up sleeping on my office floor. We didn't get much sleep! The next morning a number of us were assigned to Oak Ridge, and we stayed there for three-and-a-half to four days. Things were well organized; it was handled very well (Callas).

Management had to cut their way into Oak Ridge, as attendants had padlocked the entrance. In the end, the attendants joined the Correctional Bargaining Unit of OPSEU. This affiliation continues, even though attendants are now registered nursing assistants.